**Social History Questionnaire**

*All questions contained in this questionnaire are strictly confidential and will become part of your medical record.*

|  |  |
| --- | --- |
| Basic Information | |
| Patient Name: | Date of Birth: |

|  |  |
| --- | --- |
| Tobacco Products:  Do you have a history of smoking or currently smoking: □YES □NO  Type: □Cigarette □Cigar □Pipe  Start Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Amount of Cigarettes:  □ Less that 1 cigarette/day  □ Light (1-9 cigs/day)  □ Moderate (10-19 cigs/day)  □ Heavy (20-39 cigs/day)  □ Very Heavy (40+ Cigs/day)  Interested in quitting smoking: □YES □NO  Stop Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Smokeless:  Do you have a history with smokeless tobacco or currently us: □YES □NO  Type: □Chew □Snuff □Powder  Start Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ End Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Amount: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Interested in quitting smokeless:  □YES □NO  Stop Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |

|  |  |
| --- | --- |
| Alcohol Use:  □ Non-Drinker  □ Current Alcohol user  Type: □Beer □Hard Liquor □Wine  Drinks/Day on typical drinking day: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  High risk alcohol use: □YES □NO  Binge Drinker: □YES □NO  Past heavy use: □YES □NO  Alcohol Treatment Program: □YES □NO  Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Caffeine Use:  □ NO Caffeine use  □ Uses Caffeine  Type: □Coffee □Tea □Soda  □Energy Drinks □Caffeine Supplements  Total Amount:  □ Excessive (equivalent to 10+ 8oz Coffee per day)  □ Heavy (equivalent to 4-9 8oz Coffee per day)  □ Moderate (equivalent to 1-3 8oz Coffee per day)  □ Minimal (equivalent to <1 8oz Coffee per day)  Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| Diet Nutrition:  Difficulty Chewing: □YES □NO  Difficulty Swallowing: □YES □NO  History of Eating Disorder: □YES □NO  Financial Issues affecting the ability to buy needed food:  □YES □NO  Special Diet:  □ Diabetic □ Gluten Free □ Low Fat  □ Low Sodium □ Renal □ Vegan  □ Vegetarian □ Weight Reduction □ Other  Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Environment:  Do you live alone: □YES □NO |